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AMERICAN ACADEMY OF FAMILY PHYSICIANS

Statement of the American Academy of Family Physicians

By

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To

U.S. House Energy and Commerce Subcommittee on Health

On

# What's the Prognosis?: Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors

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Chairman Guthrie, Ranking Member Eshoo, and members of the Subcommittee: My name is Steven Furr, MD, FAAFP and I am a practicing family physician from Jackson, Alabama. I am a co-founder of Family Medical Clinic of Jackson, a rural health clinic, as well as the chief of staff of a small rural hospital and medical director of the local nursing home. As the President-Elect of the American Academy of Family Physicians (AAFP), I am honored to be here today representing the 129,600 physician and student members of the AAFP.

Today's hearing focuses on some of the most consequential issues impacting the practice of family medicine across our country. As a family physician who has cared for patients for more than 35 years, I can speak firsthand to how years of increasingly onerous administrative red tape and Medicare's repeated cuts to physician payment, while already undervaluing primary care, are fueling our primary care workforce shortage. Physician practices are staring down a number of converging policy developments in 2024 that threaten to worsen a growing primary care crisis:

- The statutory freeze on annual Medicare physician payment updates, which is exacerbating already low physician payment rates that have failed to keep up with the cost of inflation – and thus the cost of providing physician services;
- Statutory budget neutrality requirements that require CMS to offset long overdue, urgently needed investments in primary care by lowering the Medicare conversion factor, and therefore payments for every physician service;
- Across the board sequestration cuts that further reduce payments to physicians and other clinicians;
- Expiration of a geographic payment adjustment floor for physician work, which will yield greater payment cuts for rural physician practices;
- Statutory requirements that force CMS to increase the Merit-based Incentive Payment System (MIPS) performance threshold, which CMS estimates will result in a negative

payment adjustment for most clinicians in small and medium sized practices, whom patients in rural and other underserved areas rely on for their care;

- The expiration of the Advanced Alternative Payment Model (AAPM) bonus, which will undermine progress toward value-based payment models that provide clinicians with the support and flexibility they need to deliver better care at lower costs;
- And, despite the fact that the above policies will lead to compounding payment cuts for most small and medium physician practices, practices will be forced to divert significant resources to comply with a barrage of prior authorization, step therapy, quality reporting, and other administrative requirements.

Our current regulatory and policy framework fails to prioritize what actually matters most: our patients. It requires physicians to take time away from actual patient care to try and understand a health plan's arbitrary changes to their prescription drug formulary, why a prior authorization request was denied without any transparency into the requirements, or report on several different sets of quality measures, while failing to appropriately compensate us for any of that work. Primary care physicians consistently report that they are being asked to do more with less – and it's having a profound impact on our health care workforce and on patient access.

Data released just this week shows that family medicine and internal medicine physicians accounted for more than 16,000 of the 71,309 doctors who left the workforce between 2021 and 2022.[i] This already pervasive workforce shortage is only going to become more pronounced in the coming years as the average age of remaining primary care clinicians is around 60 years, according to that same data. At the same time, widespread reports indicate that our failure to support primary care physicians is worsening patients' ability to find a trusted source of primary care.

This system is actively driving prospective physicians away from primary care and imposing significant barriers on patients' access to care, particularly in rural and underserved communities. For example, our rural hospital had to stop obstetrics care – a situation that is becoming far too common in rural communities across the country. I am often asked what steps we can take to address the primary care workforce shortage and do a better job of meeting patients' needs where they are. While there is no one simple answer, we can start by doing two things: appropriately valuing and paying for the work of primary care physicians and alleviating the avalanche of administrative burden to which they're subjected.

## National Underinvestment in Primary Care

Family physicians like me are uniquely trained to care for patients across the lifespan, regardless of gender, age, or type of problem, be it physical, behavioral, or social. We serve as a trusted first contact for health concerns and are trained to address most routine health care needs. The foundation of family medicine is primary care, defined as the provision of integrated, accessible health care services by physicians and their health care teams who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. **Primary care is person-centered, team-based, community-aligned, and designed to achieve better health, better care, and lower costs.**

Primary care is the only health care component where an increased supply is associated with better population health, more equitable outcomes, and lower mortality rates, leading the National Academies of Sciences, Engineering, and Medicine (NASEM) to call it a common good.[ii] An increase of one primary care physician per 10,000 people is associated with an average mortality reduction of 5.3%, or 49 fewer deaths per 100,000 patients per year.[iii] Evidence clearly

demonstrates that improving access to longitudinal, coordinated primary care reduces costs, improves utilization of recommended preventive care, and reduces hospitalizations.

Yet the United States has continuously underinvested in primary care, which only accounts for a mere five to seven percent of total health care spending in the country despite representing over a third of all health care visits.[iv] The AAFP's Robert Graham Center, in collaboration with the Milbank Memorial Fund and the Physicians Foundation, released the nation's first primary care scorecard this year and found that primary care's share of the overall U.S. health care spend decreased from 6.2% in 2013 to 4.6% in 2020. This underinvestment in prevention and primary care is evidenced by U.S. health outcomes, with OECD data indicating that we have higher rates of obesity, diabetes, and heart disease, and a larger share of the population with multiple chronic conditions.[v]

Our existing federal policy framework fails to recognize and promote the true value of primary care. As it stands now, we financially reward individual health care transactions and financially penalize long-term relationships between a patient and primary care team. Decades of systemic underinvestment in primary care and prevention, coupled with overwhelming administrative burden, has led to poorer population health and a greater emphasis on rescue medical care, which is directly contributing to our nation's exorbitant health care spending. **The AAFP strongly urges Congress to boldly champion policies that increase our nation's investment in the comprehensive, coordinated, continuous primary care services that are proven to improve individual and population health outcomes and lower health care spending.**

## Fee-for-Service Medicare Physician Payment

High quality, comprehensive primary care is designed to deliver better health outcomes at a lower cost, by promoting preventive care and employing a person-centered approach to the management of acute and chronic physical and behavioral health conditions. Unfortunately, fee-

for-service (FFS), the dominant model of physician payment, fails to support primary care by consistently underinvesting in primary care services. Primary care spending lags in the U.S. compared to most other high-income countries.[vi] Across payers, including both public and private insurance, primary care spending in the United States amounts to approximately five to eight percent of health spending across all payers, with an even lower percentage in Medicare, compared to approximately fourteen percent of all health spending in most high-income nations. Nations with greater investment in primary care reported better patient outcomes and lower health care costs.[vii,viii,ix]

The piecemeal approach FFS payment, including the Medicare Physician Fee Schedule (MPFS), takes to financing primary care undermines and undervalues the whole-person approach integral to primary care. Across payers, physicians must document several unique screening codes, vaccine administration, other preventive services and counseling codes, an office visit, care management codes, integrated behavioral health codes, and several other services to justify payment for typical, comprehensive primary care, even though these services are all foundational parts of primary care. The retrospective, volume-based nature of FFS therefore fails to account for the costs of longitudinally managing patients' overall health, nor does FFS provide practices with the time and flexibility to invest in the care management staff and population health tools that enable practices to efficiently and effectively meet patients' individual evolving health needs.

For these reasons, the AAFP has long advocated to accelerate the transition to value-based care using alternative payment models (APMs) that provide prospective, population-based payments to support the provision of comprehensive, longitudinal primary care. We strongly believe that well-designed APMs provide primary care a path out of the under-valued and overly-burdensome FFS primary care payment system that exists today, and in turn will better enable the Medicare program to meet the needs of its growing and aging beneficiary population. However, existing value-based payment arrangements are based upon a FFS chassis.

Therefore, while FFS is not the future the AAFP envisions for primary care, it is the present. Federal policymakers must ensure the current FFS system appropriately and sustainably compensates physicians to make more meaningful progress toward the future – one that rewards quality of care over volume of services. The AAFP has been encouraged by recent regulatory policy changes aimed at more appropriately valuing and paying for primary care and other types of cognitive care in Medicare, but additional steps are needed to correct the historic underinvestment and secure timely access to primary care in the years to come.

For 2024, the Centers for Medicare and Medicaid Services (CMS) are proposing one short-term but meaningful step toward ensuring that fee-for-service is better valuing and paying for primary care through the implementation of an add-on billing code known as G2211. G2211 would be billed with codes for office/outpatient evaluation and management (E/M) visits to better recognize the inherent resource costs clinicians incur when longitudinally managing a patient's overall health or treating a patient's single, serious or complex chronic condition. In simpler terms, G2211 reflects the time, intensity, and practice expenses needed to meaningfully establish relationships with patients and address most of their health care needs with consistency and continuity.

**The Academy, alongside 36 other organizations representing clinicians, patient advocates, and other health care stakeholders, has strongly urged Congress to support CMS' proposal to implement G2211 as it would invest in and improve access to comprehensive, longitudinal, patient-centered care.** Studies confirm that office visits provided by family medicine and internal medicine physicians are more complex than those provided by other specialties.[x] This complexity includes management of multiple interdependent conditions, balancing multiple clinical guidelines, registries, and coordination of care across a large team. Existing processes for creating and valuing office visit and other codes fail to account for this additional complexity because they consider the "typical" patient and office visit across all medical specialties.

Further, sustained continuity of care has been shown to improve quality and reduce health care spending by improving uptake of preventive services, increasing adherence to care plans for patients with chronic conditions such as diabetes, and decreasing hospitalizations and emergency department use overall.[xi] This add-on code is a much-needed investment in strengthening patient-clinician relationships by supporting clinicians 'ability to foster longitudinal relationships, address unmet social needs, and coordinate patient care across the team. Evidence indicates increasing payments for these types of services reduce patient appointment wait times and supports the provision of services that improve patient health and can reduce costs.[xii,xiii,xiv]

Allowing this code to go into effect would be an incremental but necessary step toward bolstering access to the comprehensive primary care Medicare beneficiaries need and appropriately paying for the complex care that primary care physicians provide each and every day, with the likelihood to yield long-term health care savings.

However, more significant reforms are needed to fix the flawed Medicare payment system and support all physicians across the country. **The Academy has strongly urged Congress to consider legislative solutions, including reforms to MACRA, that would address unsustainable FFS payment rates for physicians, promote patients' access to continuous, comprehensive primary care, and improve health outcomes.** We appreciate the Subcommittee's attention to this important topic today by considering many pieces of legislation that seek to address these issues.

The zero-sum, budget-neutral nature of the physician fee schedule means that Medicare is unable to appropriately pay for all of the services that a beneficiary might need. The AAFP and many other physician specialties have long advocated for Congress to address these underlying problems in the Medicare statute, which result in untenable annual payment reductions for all

physicians and undermine positive policy changes intended to correct the historic underinvestment in continuous, coordinated care. I applaud the recent introduction of a legislative discussion draft that proposes to reform the existing budget neutrality requirements. This is an important first step and I look forward to working with the Subcommittee and others to build upon these proposals and advance policies that will meaningfully reform budget neutrality to strengthen Medicare for physicians and their patients.

Additionally, physician payment is the only system under Medicare that does not currently receive an annual inflationary update. There is a significant discrepancy between what it costs to run a physician practice and the actual payment we receive, placing many small, independent practices in a state of financial ruin that leaves them with virtually no options other than to be acquired by a health system or payer, or close their doors entirely. **The Academy has strongly advocated alongside the entire physician community in support of the *Strengthening Medicare for Patients and Providers Act* (H.R. 2474), which would provide an annual inflationary update to Medicare physician payment based upon the Medicare Economic Index (MEI).** In addition to the legislation before you today, I urge the Subcommittee to consider this important bill and thank Subcommittee members Representatives Bucshon, Ruiz, and Miller-Meeks for their leadership as sponsors.

In addition to already being insufficient, Medicare payments for physician services are adjusted based on the geographic area where a physician works through geographic practice cost indices (GPCIs). Specifically, Medicare will pay more for a physician's service in an area where approximate costs for a physician's time, skills, and effort are higher than the national average and less in an area where costs are lower. This current structure of low payment can prevent rural physicians from being able to feasibly accept as many patients as urban and suburban physicians, further disadvantaging individuals living in those areas and consequently reducing their access to primary care services.

**For these reasons, the Academy strongly supports the elimination of all geographic adjustment factors from the Medicare Physician Fee Schedule except for those designed to achieve a specific public policy goal**, such as encouraging physicians to practice in underserved areas. Congress has previously acted to apply a temporary floor of 1.0 to raise the physician work GPCI value to the national average for localities with values below it. That floor is set to expire at the end of this year without Congressional action, which would result in even greater payment cuts for rural physician practices and undoubtedly jeopardize their ability to stay financially afloat. GPCI floors reduce the geographic variations in Medicare payments, a step toward the elimination of geographic modifiers for which the AAFP advocates.

If we want to do a better job of recruiting and retaining rural physicians, this is one place to start. Patient care provided in a rural area should not be valued less by Medicare than physician work provided elsewhere. Therefore, I appreciate the Subcommittee's attention to this important issue with today's considered legislation and urge that Congressional action be taken to, at a minimum, extend the physician work GPCI floor of 1.0 to any locality that would otherwise have an index value below that level.

Overall, budget-neutrality requirements, arbitrary geographic adjustments, and insufficient Medicare payment will continue to hurt physician practices, slow the adoption of value-based payment models, accelerate consolidation, and jeopardize patients 'access to care – all while increasing federal health care spending – if Congress does not intervene. The AAFP urges Congress to expeditiously consider additional reforms to MACRA and Medicare physician payment, such as relief from budget neutrality requirements, to modernize Medicare fee-for-service payments.

## Value-Based Payment and Alternative Payment Models

Alternative payment models, when well-designed and implemented to meaningfully support primary care, provide practices with predictable, stable revenue streams that give the financial flexibility to provide truly patient-centered care. The AAFP has developed a set of Guiding Principles for Value-based Payment as a reference point for physicians and other stakeholders to evaluate whether primary care alternative payment models (APMs) are designed to meet their stated goal: improving patient health outcomes through quality improvement with accountability for health care spending.

The Merit-based Incentive Payment System (MIPS) was originally envisioned by MACRA to provide clinicians with experience being measured on their performance to help them move into APMs. The AAFP supported the intent of fostering continuous performance improvements that lead to better outcomes for patients. Unfortunately, continuous cuts to Medicare FFS payments have inhibited most practices from making the necessary investments that would allow them to successfully move into APMs. Further, we are concerned that the current design of MIPS, which focuses on individual clinician performance using largely process rather than outcomes measures, is not driving care improvements as much as it is adding administrative complexities that detract from patient care while unfairly penalizing small and rural practices.

MACRA requires CMS to apply payment adjustments to Medicare Part B FFS payments based on an eligible clinician's (EC) performance in MIPS. Clinicians with a MIPS final score above the performance threshold receive a positive adjustment while those below the threshold receive a negative adjustment. The adjustments must be budget neutral – meaning the total value of annual positive adjustments are equal to the total value of negative adjustments. As such, both the positive and negative adjustments are made on a sliding scale with the exception that those in the bottom quartile automatically receive the maximum penalty for the year.

While most physicians have met or exceeded the MIPS performance threshold in past performance years, physicians in small and rural practices consistently have lower than average MIPS scores. As the performance threshold increases, it will become more difficult for small and rural practices to avoid a penalty.

In CY2024, CMS is proposing to increase the MIPS performance threshold due to requirements enacted by MACRA. The estimated impact of the increased threshold is significant – nearly half of all ECs would receive a penalty based on the proposed increase. Even more alarming, CMS estimates that nearly 65% of ECs in solo practices, 60% of ECs in small practices, and 62% of ECs in practices with 16- 99 clinicians will receive a penalty, confirming that the MIPS program is using negative payment adjustments from the majority of clinicians in small practices to fund positive adjustments for clinicians working in large health systems. **These estimates demonstrate that the MIPS program is not driving continuous quality improvement and is instead on a path that will accelerate the closing and consolidation of small physician practices.**

The AAFP urges Congress to consider reforms to the MIPS program to alleviate the administrative costs of reporting to the program, ensure it drives meaningful quality improvement, and assist physician practices in building the necessary competencies to transition into alternative payment models.

We also appreciate legislation before the Subcommittee today that would extend the Quality Payment Program's Small, Underserved, and Rural Practices support program, which expired in 2022, for another five years. This technical assistance program provided hands-on training to help thousands of small practices successfully report to MIPS, particularly those that were rural and under-resourced. For example, clinicians received help choosing and reporting on quality measures, as well as guidance with all aspects of the program, including supporting change

management and strategic planning and assessing and optimizing health information technology. The training and education resources were available at no cost to eligible clinicians and practices.

Congressional action is also needed to ensure that federal policies provide appropriate support and incentives to physician practices moving into APMs. I appreciate the Subcommittee taking steps towards doing so today by considering legislation that would extend the original five percent incentive payment for Advanced APM (AAPM) participation. Extending this incentive payment is vital to encouraging physician practices to enter into APMs and ensure that Medicare's physician payment policies do not disincentivize participation in APMs in the years to come. The AAFP strongly urges Congress to enact this extension. To build upon this, Congress should also consider legislation to provide CMS with authority to modify AAPM qualifying participant thresholds to ensure that independent practices are not left behind. The *Value in Health Care Act* (H.R. 5013), which the AAFP has endorsed, is one proposal that would do so.

Federal policymakers should increase participation opportunities in primary care models that align with the AAFP's aforementioned principles for value-based payment and meet practices where they are, allowing them to gain a foothold in value-based payment. However, primary care practices face significant barriers to entering value-based payment models, even when aligned with our principles. Practices must ensure compliance with ever-changing federal regulations, negotiate value-based contracts with multiple commercial payers, establish and maintain a robust panel of attributed patients, acquire and effectively use data aggregation and analysis software to track patient utilization, treatment adherence, and identify outstanding needs.

This creates an immediate high barrier to entry, forcing physicians to choose between remaining stuck in a fee-for-service environment that fails to support the full scope of comprehensive, longitudinal primary care, or join with a third-party, larger practice, health system, or payer that can provide them with the tools and support they need to thrive in value-based arrangements. Federal

policymakers should increase participation options in APMs that provide upfront or advance payments to enable the infrastructure investments and practice transformations necessary to succeed in value-based payment.

The AAFP is encouraged by two new models announced by the Center for Medicare and Medicaid Innovation (CMMI) that seek to expand primary care model opportunities, provide upfront support for practices moving into APMs, and increase investment in primary care through prospective, population-based payments that are designed to support comprehensive primary care. We are also particularly supportive of CMMI's focus on increasing APM opportunities that are inclusive of Medicaid beneficiaries and the clinicians who care for them. We urge Congress to support CMMI's ongoing work to accelerate the transition to value-based care.

**Administrative Burden and Measurement Reporting**

1. *Prior authorization:*

Commercial insurers – including those that administer Medicare Advantage (MA) and Medicaid managed care plans – often use utilization management processes such as prior authorization and step therapy for what they describe as cost-control. However, repeated evidence has shown that many health plans use utilization management processes inappropriately, causing care delays and worsening patient outcomes and satisfaction. A 2022 report from the Department of Health and Human Services (HHS) Office of Inspector General (OIG) confirmed that MA plans sometimes deny prior authorization and payment requests that meet Medicare coverage rules by using clinical criteria not in those rules and requesting unnecessary documentation, as well as making errors in interpretation of those rules.

In addition to enrollees in MA plans, enrollees in other health plans needing care for their own chronic illness,[xv] their children's chronic illness,[xvi] and for rare diseases[xvii] have experienced barriers to care from prior authorization requirements. In 2022, California-based L.A. Care, which administers Medicaid and other types of coverage, failed to address a backlog of more than 9,000 prior authorization requests and more than 67,000 complaints or appeals.[xviii] Meanwhile, an Office of Inspector General report published in July found that Medicaid managed care organizations (MCOs) denied one out of every eight prior authorization requests in 2019, yet minimal data collection on and oversight of these practices is being done by state Medicaid agencies.[xix]

In an American Medical Association (AMA) survey of physicians, 94 percent reported that prior authorization delays access to care, while 80 percent reported that it led to patients abandoning their treatment and 33 percent reported that it had led to a serious adverse event for their patient. Additionally, 86 percent of surveyed physicians reported that prior authorization sometimes, always, or often leads to higher overall utilization of health care resources, such as additional office visits, emergency department visits, or hospitalizations.

Some plans have made it so difficult to receive prior authorization for necessary tests, such as MRIs, nerve conduction studies, or cardiac stress tests, that it is easier to refer patients to a specialist and let them order the test. However, that requires an unnecessary, more expensive office visit for the patient – which is antithetical to the purported "cost saving" purpose of prior authorization. And even then, some specialists will refuse to see a patient until you've already ordered the MRI. Jumping through the hoops of this impossible system benefits neither the patients nor the physicians.

For these reasons, the AAFP has strongly supported Congressional efforts to streamline and implement prior authorization reporting requirements as a means to address some of the unrelenting administrative burden physicians are subject to and ensure better patient access to

care. This includes endorsing the bipartisan *Improving Seniors' Timely Access to Care Act*, which I am pleased is being considered by the Subcommittee as part of today's conversation. This necessary legislation would require implementation of an electric prior authorization program in Medicare Advantage (MA), as well as require MA plans to provide real-time decisions and increase the transparency of their prior authorization requirements. Additionally, Congress could also consider requiring data collection and greater oversight by state Medicaid agencies on the use of prior authorization by Medicaid managed care plans, as well as providing CMS with additional authority to conduct oversight of the use of utilization management requirements.

*2. Step therapy and prescription drug formularies:*

In my experience as a practicing physician, the single greatest administrative burden I'm facing is sudden, arbitrary changes to a patient's medication coverage by their health plan. A patient can be doing well on a specific medication for years, and one day the plan no longer covers it or has a preferred alternative.

Step therapy, often known as "fail first," is a health plan protocol that requires patients to try one or more insurer-preferred medication prior to the medication their physician prescribed. This practice can take weeks or months and can result in patients not being able to access the treatments they need in a timely manner. Physicians can request exceptions to step therapy requirements, but insurers may not respond promptly to such requests, resulting in a further delay of treatment. Research has demonstrated that step therapy requirements prevent patients from adhering to effective medication regimens, which can lead to worse health outcomes.

I have seen patients lose control of their previously well-managed diabetes and hypertension as a result of these tactics, in addition to requiring more office visits and in some cases emergency department visits and hospital stays. Insurers are even requiring step therapy for inexpensive

generic medications. When a medication coverage changes, physicians are often only told that the medication is not covered – we are not given any additional information, such as a list of alternatives that *are* covered. This means we can spend a great deal of time going back-and-forth with the pharmacy trying to figure out what alternative medicine is covered by their plan. Formulary changes must be made known to physicians and pharmacies prior to implementation.

The AAFP recently supported a CMS proposal to require Medicare Advantage plans to implement electronic health standards that enable clinicians to query patients' formularies in real time at the point of care. Congress should encourage the adoption of such standards across payers and programs. Additionally, the patient should be allowed to continue with a previously approved drug until and unless a physician, in consultation with the patient, decides to change to another drug. **I urge Congress to take action to reign in these burdensome and, quite frankly, harmful processes by requiring greater transparency, streamlined requirements, and timely responses by health plans as well as reasonable exceptions to any step therapy protocol.**

*3. Part B coverage of vaccines:*

Additionally, Medicare's bifurcated approach to vaccine coverage is preventing many beneficiaries from being able to access newly recommended vaccines from their trusted source of care, like their family physician. Vaccines are the safest and most cost-effective public health technology we have. Current adult vaccination coverage yields an estimated 65 million averted disease cases and $185 billion in averted case costs over a 30-year period.[xx] The COVID-19 pandemic was a real-time demonstration of the invaluable role that vaccines play in saving lives, when they are affordable and accessible. Yet each year, the United States spends $27 billion on four vaccine-preventable illnesses in adults over the age of 50: flu, pertussis, pneumococcal pneumonia, and shingles.[xxi]

Medicare currently splits vaccine coverage between Part B (outpatient care) and Part D (prescription drug coverage). New vaccines, such as those against Respiratory Synsitial Virus (RSV), are only covered under Medicare Part D, which is designed for pharmacies to submit claims, not for physicians, and therefore prevents primary care physicians like me to deliver recommended vaccines in the office. Since most physicians can't bill Part D for vaccine services, many physician practices do not stock vaccines that are recommended for seniors and only covered under Part D, like the shingles and RSV vaccines, and instead have to refer our patients to the pharmacy. Patients then have to identify and secure a separate appointment at an in-network pharmacy to be vaccinated. In reality, most of my patients are not going to do that. Further, approximately 8.5 million Medicare enrollees have Part B but not Part D coverage, leaving them without affordable access to Part D vaccines.[xxii]

Legislative action is needed to ensure that family physicians can easily provide <u>all</u> ACIP-recommended vaccines to Medicare beneficiaries in their offices. **I urge Congress to pass legislation to require Medicare Part B coverage of all ACIP-recommended vaccines, allowing beneficiaries to more readily access vaccines from their usual source of care and improving our nation's uptake of one of the most cost-effective public health measures.**

*4. <u>Quality/performance measurement and reporting:</u>*

Quality and performance measurement has proliferated in the past 25 years, leading to significant burdens on physicians. This is especially true for primary care physicians, who are disproportionately accountable for a growing number of disease-specific process measures that fail to capture the true nature and value of comprehensive, patient-centered primary care.

While quality measurement is essential to moving toward a value-based health care system, our current approach fails to measure what matters to patients and clinicians or drive meaningful

quality improvement. The eagerness to measure has burdened family physicians with the onerous task of capturing structured electronic data to feed an excessive number of measures, taken time away from patients, and led to loss of joy in practice. **Quality measurement has become a high-burden, high-cost administrative exercise, focused on financial concerns with little benefit to patient care, population health, and cost reduction.** Thirty-three percent of family physicians cited the lack of evidence that using performance measures results in better patient care as a major weakness of value-based payment systems, and an additional 29 percent cited this as a minor weakness.[xxiii] The burden of measurement contributes to burnout among primary care teams, which in turn is associated with lower quality of care.

**We must standardize quality and performance measures with a single universal set – across payers and programs – that meets the highest standards of validity and reliability and is derived from data extracted from multiple data sources.** The measures should focus on outcomes that matter most to patients and that have the greatest overall impact on better health of the population, better health care, and lower costs. Right now, it is a logistical nightmare to try and meet all of the different quality measures across plans. On average, family medicine practices contract with about 10 different payers. Keeping track of and successfully reporting different measures for each of these payers creates confusion and additional reporting burden and can actually undermine meaningful practice improvements.

Aligning measures across payers will also help to identify disparities in care quality (and, in some cases, utilization and access) across different payers, states, and lines of service. Greater alignment will also drive improvements in data collection automation, which will reduce reporting burden on family physicians and other clinicians.

Importantly, measures must reflect things which a physician can control instead of penalizing them for the things they can't. For example, I use a code that indicates I offered the patient a vaccine but

they refused to take it. However, the measures only reflect that the patient chose not to get a recommended vaccine - the fact that I offered it has no impact. Performance measurement should focus on improving outcomes that matter most to patients and have the greatest impact on improving the health of the population, creating a better experience of care, and lowering the per capita cost of care, while also returning joy to the practice of caregiving for physicians and other clinicians.

As a starting point for reform, the AAFP is pleased to support the *Fewer Burdens for Better Care Act*, which is before the Subcommittee today. There currently exists a mandated pre-rulemaking process by which stakeholders can comment on the selection of and creation of new Medicare quality measures. However, no such process exists for collecting feedback on which quality measures should be removed. This legislation would require HHS to establish a parallel pre-rulemaking process for stakeholders to provide comments and feedback to CMS on the removal of Medicare quality measures. The AAFP has long protested the health care system's scattershot approach to quality measurement, which requires physicians to report on multiple sets of performance measures, and continues to press for reform. I believe development of such a process would be a valuable opportunity for physician input and would be an important step toward reforming the burdensome quality measurement framework that we're currently subject to.

In closing, thank you again for the opportunity to provide this testimony. On behalf of the AAFP and as a family physician, I look forward to working with the Subcommittee to advance policies that invest in high-quality primary care, improve patients' access to care, and better support physicians by more appropriately paying for the work being done while addressing the overwhelming mountain of administrative burden to which they're currently subjected.

*Founded in 1947, the AAFP represents 129,600 physicians and medical students nationwide. It is the largest medical society devoted solely to primary care. Family physicians conduct approximately one in five office visits -- that's 192 million visits annually or 48 percent more than the next most visited medical specialty. Today, family physicians provide more care for America's underserved and rural populations than any other medical specialty. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focused on integrated care. To learn more about the specialty of family medicine and the AAFP's positions*

*on issues and clinical care, visit www.aafp.org. For information about health care, health conditions and wellness, please visit the AAFP's consumer website, www.familydoctor.org.*

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[i] Primary care, mental health clinician shortage jeopardizes access | Modern Healthcare

[ii] National Academies of Sciences, Engineering, and Medicine. 2021. Implementing high-quality PC: Rebuilding the foundation of health care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983

[iii] Macinko J, Starfield B, Shi L. Quantifying the health benefits of primary care physician supply in the United States. Int J Health Serv. 2007;37(1):111-26. doi: 10.2190/3431-G6T7-37M8-P224. PMID: 17436988.

[iv] Jabbarpour Y, Greiner A, Jetty A, et al. Investing in Primary Care: A State-Level Analysis. Patient-Centered Primary Care Collaborative and the Robert Graham Center; July 2019. https://www.grahamcenter.org/content/dam/rgc/documents/publications-reports/reports/ Investing-Primary-Care-State-LevelPCMH-Report.pdf. Accessed February 9, 2023.

[v] Turner A, Miller G, and E Lowry. "High U.S. Health Care Spending: Where Is It All Going?," The Commonwealth Fund. Published October 4, 2023. Available online at: https://www.commonwealthfund.org/publications/issue-briefs/2023/oct/high-us-health-care-spending-where-is-it-all-going

[vi] Primary Care Collaborative, Robert Graham Center. Investing in Primary Care: A State-Level Analysis. 2019. Available at: https://www.aafp.org/dam/AAFP/documents/advocacy/payment/apms/BKG-PrimaryCareSpend.pdf

[vii] Primary Care Collaborative. (2020). "Spending for Primary Care Fact Sheet."

[viii] Reid R, Damberg C, Friedberg MW. (2019). "Primary Care Spending in the Fee-for-Service Medicare Population." JAMA Intern Med. Web.

[ix] Shi L. (2012). "The Impact of Primary Care: A Focused Review." Scientifica (Cairo). Web.

[x] Katerndahl, D; Wood, R; Jaén, CR. Complexity of ambulatory care across disciplines. Healthcare. 2015, Available at: https://doi.org/10.1016/j.hjdsi.2015.02.002.

[xi] Cabana MD, Jee SH. Does continuity of care improve patient outcomes? J Fam Pract. 2004 Dec;53(12):974-80. PMID: 15581440.

[xii] Increased Medicaid Reimbursement Rates Expand Access to Care. National Bureau of Economic Research. 2019.

[xiii] Candon M, Zuckerman S, Wissoker D, et al. Declining Medicaid Fees and Primary Care Appointment Availability for New Medicaid Patients. JAMA Intern Med. 2018;178(1):145–146. Doi:10.1001/jamainternmed.2017.6302

[xiv] Williams MD, Asiedu GB, Finnie D, et al. Sustainable care coordination: a qualitative study of primary care provider, administrator, and insurer perspectives. BMC Health Serv Res. 2019;19(1):92. Published 2019 Feb 1. Doi:10.1186/s12913-019-3916-5

[xv] i Armstrong D, Rucker P, Miller M. 2023. UnitedHealthcare Tried to Deny Coverage to a Chronically Ill Patient. He Fought Back, Exposing the Insurer's Inner Workings. Propublica. https://www.propublica.org/article/unitedhealth-healthcare-insurance-denial-ulcerative-colitis

[xvi] Dickens DS, Pollock BH. Medication prior authorization in pediatric hematology and oncology. Pediatr Blood Cancer. 2017 Jun;64(6). doi: 10.1002/pbc.26339. Epub 2016 Nov 5. PMID: 28436209. https://pubmed.ncbi.nlm.nih.gov/28436209/

[xvii] Johnson CY. 2023. I wrote about high-priced drugs for years. Then my toddler needed one. Washington Post. https://www.washingtonpost.com/wellness/2023/01/30/high-priced-drugs-step-insurance-policies/

[xviii] Liss S. 2022. L.A. Care fined $55M after members faced barriers to timely care. Healthcare Dive. https://www.healthcaredive.com/news/la-care-55m-fine-members-barriers-timelycare/619925/#:%7E:text=L.A.%20Care%2C%20the%20nation%27s%20largest,Managed%20Health%20Care% 20announced%20Friday.

[xix] Grimm CA, "High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care." Office of Inspector General, U.S. Department of Health and Human Services. Published July 2023. Available online at: https://oig.hhs.gov/oei/reports/OEI-09-19-00350.asp.

[xx] Carrico J et al. "Cost-benefit analysis of vaccination against four preventable diseases in older adults: Impact of an aging population," *Vaccine* Volume 39, Issue 36, 23 August 2021, Pages 5187-5197. https://doi.org/10.1016/j.vaccine.2021.07.029.

[xxi] McLaughlin JM, McGinnis JJ, Tan L, Mercatante A, Fortuna J. Estimated Human and Economic Burden of Four Major Adult Vaccine-Preventable Diseases in the United States, 2013. J Prim Prev. 2015 Aug;36(4):259-73. doi: 10.1007/s10935-015-0394-3. PMID: 26032932; PMCID: PMC4486398.
[xxii] Centers for Medicare and Medicaid Services, "Medicare Monthly Enrollment." Updated June 2023. Accessed October 10, 2023. Available online at: https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment/data?query=
[xxiii] American Academy of Family Physicians. 2017 value-based payment survey Accessed October 15, 2018.